

PEDIATRIC VISIT 2 YEARS

DATE OF SERVICE _____

NAME _____ M / F DATE OF BIRTH _____ AGE _____

WEIGHT _____ / _____ % HEIGHT _____ / _____ % BMI _____ / _____ % TEMP _____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____

Family health history updated? _____

Reactions to immunizations? Yes / No _____

Concerns: _____

PSYCHOSOCIAL ASSESSMENT:**Sleep:** _____ **Child care:** _____**Recent changes in family:** *(circle all that apply)*

New members, separation, chronic illness, death, recent move, loss of job, other _____

Environment: Smokers in home? Yes / No**Violence Assessment:**

History of injuries, accidents? Yes / No

Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT: CHOL TB LEAD
(Circle) Pos / Neg Pos / Neg Pos / Neg**PHYSICAL EXAMINATION:**Wnl Abn *(describe abnormalities)*☐ ☐ Appearance/Interaction☐ ☐ Growth☐ ☐ Skin☐ ☐ Head/Face☐ ☐ Eyes/Red reflex/Cover test☐ ☐ Ears☐ ☐ Nose☐ ☐ Mouth/Gums/Dentition☐ ☐ Neck/Nodes☐ ☐ Lungs☐ ☐ Heart/Pulses☐ ☐ Chest/Breasts☐ ☐ Abdomen☐ ☐ Genitals☐ ☐ Extremities/Hips/Feet☐ ☐ Neuro/Reflexes/Tone☐ ☐ Vision *(gross assessment)*☐ ☐ Hearing *(gross assessment)*

NUTRITIONAL ASSESSMENT:**Typical diet:** *(specify foods):* _____**Education:** Offer variety of nutritious foods ☐ 5 fruits/vegetables daily ☐Child sized portions ☐ Avoid struggles over eating ☐ Eat with family ☐**DEVELOPMENTAL SCREENING:** *(With Standardized Tool)*
REQUIRED**ASQ:** ☐ **PEDs** ☐ **Other:** ☐ *(specify)* _____**Results:** Wnl ☐ **Areas of Concern:** _____**Referred:** Yes / No **Where?** _____**MCHAT** Required ☐**DEVELOPMENTAL SURVEILLANCE:** *(Observed or Reported)***Social:** Helps with simple tasks ☐ Puts on clothing ☐ Brushes teeth ☐Washes and dries hands ☐ Plays interactive games ☐Separates from mother ☐**Fine Motor:** Scribbles ☐ Tower of 4-6 cubes ☐ Copies vertical line ☐Uses spoon well ☐**Language:** Combines 2 words ☐ Knows 3-5 named body parts ☐Follows 2 part directions ☐ Understands cold, tired, hungry ☐Gives first and last name ☐ Picks longer line ☐Names 1 picture (cat, bird, horse, dog, person) ☐**Gross Motor:** Kicks ball ☐ Runs well ☐ Walks up steps ☐ Jumps ☐Balances on 1 foot-1 second ☐ Pedals tricycle ☐Throws ball overhand ☐**ANTICIPATORY GUIDANCE:** *(Check all that were discussed)***Social:** Aware of self/different from others ☐ Needs peer contact ☐Dawdling is normal ☐ Resolving negativism ☐Power struggles occur ☐**Parenting:** Toilet training (relaxed, praise success) ☐ Sexuality ☐Help teach self-control ☐ Offer choice, give simple tasks ☐Tantrums (ignore, distract, sympathize) ☐**Play and communication:** Small table and chairs ☐Stories and music ☐ Building materials ☐**Health:** Avoid bubble baths ☐ Night fears ☐ Brush teeth ☐Fluoride if well water ☐ Biting, kicking stage ☐ Use sunscreen ☐Physical activity ☐ Second hand smoke ☐ Tick prevention ☐**Injury prevention:** Car seat ☐ Rear riding seat ☐ Poison control # ☐Hot water at 120° ☐ Water safety (tub, pool) ☐ Toddler proof home ☐Smoke detector/escape plan ☐ Hot liquids ☐ Choking/suffocation ☐Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐**PLANS**1. Review immunizations and bring up to date ☐ _____2. Second Lead/HCT test required ☐ _____3. Speech referral if delayed ☐ _____4. PPD, if risk assessment is positive ☐ _____5. Dental visit advised ☐ Date of Last Dental Exam _____

6. Testing/counseling, if cholesterol risk assessment is positive _____

7. Fluoride Varnish Applied? Yes / No _____

8. Next preventive appointment at 30 Months ☐ _____9. Referrals for identified problems? *(specify)* _____**Signatures:** _____